Gilbert Podiatry Associates, P.C.
P.O. Box 125; 1310 Route 209 Suite 107
Gilbert, PA 18331

Name:_____

Street Address:_____

City:_____State:_____Zip:_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Other Phone (i.e. work, etc.): (_____)_____-_____

Date of Birth:_____/_____/_____Social Security Number:_____-_____-_____

Sex: Male Female Marital Status: S / M / W

Primary Physician:_____

Referred By:_____

Insurance Information (<u>please present cards for copying</u>)

Subscriber (if other than self)

Primary Insurance:_____ Name:_____

Policy ID Number:_____ Address:_____

Group Number:_____ _____

Secondary Insurance:_____ Relationship:_____

Policy ID Number:_____ Date of Birth:_____/_____/_____

Group Number:_____ Social Security Number:_____-_____-_____

Patient/Insurance Agreement:

I authorize the release of medical information to process claims for services rendered and I also authorize the payment of medical benefits directly to Gilbert Podiatry Associates, P.C. I will be responsible for all balances due to Gilbert Podiatry Associates, P.C. for all services rendered. I understand this authorization is voluntary. I understand that this authorization is in effect until I notify you in writing of revocation.

Patient signature:_____Date:_____/_____/_____

Medicare Insurance Agreement:

I authorize the holder of medical or other information about me to release to the Social Security Administration and HCFA or its intermediaries or carriers any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient signature:_____Date:_____/_____/_____